THE SUBSTANCE MISUSE FIELD'S NO.1 MAGAZINE

DDN
Drink and Drugs News

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'The idea is that you have a pathway from the street into supported housing and then into independent housing... What you can't do is put people in mainstream housing and leave them there.'

LIVING IN A DREAM

ARE DECENT PATHWAYS TO HOUSING JUST FANTASY?


Adfam has supported families affected by drugs and alcohol for the last 30 years. For our birthday this year, we want to end the stigma suffered by millions of people living with an addiction – that's not theirs. With your support, we'll help end their isolation and encourage them to speak out. That's the best birthday present we could wish for.
30th
Adfam
Families, drugs and alcohol
www.adfam.org.uk
"Angry
Because I'm blamed for my son's addiction"
Paula
Challenging stigma and how to support family members are two of the issues that will be addressed at the third FAMILIES FIRST CONFERENCE on 23 October in London. For more details visit www.drinkanddrugsnews.com

DDN Drink and Drugs News

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Editorial – Claire Brown

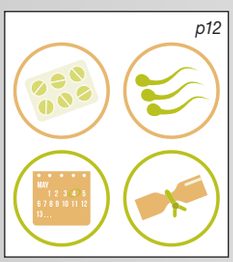
In times of need

When the going gets tough, find a partner

'IT'S A CRITICAL TIME of challenge, but also of opportunity,' said Marcus Roberts at the recent Recovery Festival (page 8). We're well aware of the challenges, and that services for vulnerable people are likely to remain under extreme threat during the next couple of years. But there are signs of strong partnerships between the housing and treatment sectors, and with employers who are willing to tackle stigma head-on to get people back into work (page 14). CNWL have created entry points through a peer support network; Kaleidoscope are working in partnership with local industry to support the workforce before problems develop; and major law firm Freshfields Bruckhaus Deringer have actively engaged in a programme called 'Ready for Work' to offer people with convictions placements among their support staff – an important signal that such initiatives can be undertaken very successfully.

'Create opportunities if they're not available,' urges Sunny Dhadley (page 16), taking Wolverhampton's service user involvement team from strength to strength. Against the backdrop of constant funding constraints and competition this may seem an uphill task, but evidence of inspiration and progress should give us hope.

This issue



FEATURES

REGULARS

NEWS IN BRIEF

PSYCHOACTIVE SURVEY

A consultation on new psychoactive substances has been launched by the National Assembly for Wales' health and social care committee, looking at issues like awareness, legislation, service capacity, partnership working, data collection and international evidence. The committee is looking for submissions from both individuals and organisations and the consultation, which has been welcomed by the BMA, runs until 26 September. 'Our members are increasingly seeing problems as a result of these substances,' said BMA Welsh secretary Richard Lewis. 'Health and education services need to have a consistent way of monitoring these changes as new products are coming out all of the time.' *Consultation at www.senedd.assemblywales.org*

ACMD ADDITIONS

Nine new members have been appointed to the Advisory Council on the Misuse of Drugs, including DrugScope chief executive Marcus Roberts and professor of neuropharmacology at the University of Reading, Ben Whalley. 'Their considerable experience and expertise will further strengthen our council,' said ACMD chair Les Iversen.

CONTINENTAL COMPARISONS

A Europe-wide overview of the history and availability of residential provision in different national drug treatment systems has been published by EMCDDA. Among the areas looked at in *Residential treatment for drug use in Europe* are coverage, organisational structure and treatment components. *Available at www.emcdda.europa.eu*

A BRIEF WORD

More than 100 people attended a training and networking event in Monmouth last month to promote 'Have a Word', the national alcohol brief intervention training programme for Wales. 'The "Have a Word" training has enabled over 6,000 people in Wales to identify hazardous and harmful drinkers and provide advice to reduce alcohol-related harm,' said the Kaleidoscope Project's alcohol service team leader and training coordinator, Tom Damsell. 'By working in collaboration with Public Health Wales to deliver the training and by putting on events like this, I hope that in a few years time alcohol brief intervention training will be commonplace and fewer and fewer problem drinkers will be slipping through the net into alcohol dependency.'

SENSITIVE SUBJECTS

A briefing to help ensure that pupils receive relevant alcohol and drug education in the context of cultural differences has been published by Mentor ADEPIS. *Making it inclusive: alcohol and drug education in multicultural settings* sets out the key requirements for 'culturally sensitive' teaching. *Available at mentor-adepis.org*

'New pledges' announced as part of alcohol deal

A set of new pledges has been announced by the government as part of its 'responsibility deal' with the alcohol industry. They include an end to the sale of super-strength drinks in large cans and more 'responsible' displays and promotions in shops.

There is also a commitment to promoting lower-alcohol products in pubs and bars, and making sure that house wines below 12.5 per cent are always available. Initial funding of £250,000 from the drinks industry to provide alcohol education programmes in schools has also been announced.

The responsibility deal was launched as a partnership between the government, the industry and the voluntary sector, alongside similar arrangements with the food industry and others, and originally announced in the 2010 public health white paper (*DDN*, 6 December 2010, page 4). Controversial from the start, it was branded 'the worst possible deal for everyone who wants to see alcohol harm reduced' by Alcohol Concern (*DDN*, April 2011, page 4), with the charity refusing to sign up – along with the Royal College of Physicians, the British Medical Association and the British Liver Trust – despite government claims that the arrangement would deliver 'faster and better' results than legislation.

Other organisations including Cancer Research and the Faculty of Public Health later withdrew from the responsibility deal network following the government's announcement that it was not planning to introduce a minimum unit price (*DDN*, August 2013, page 4), and although the government has said the aim is to remove a billion units of alcohol from the market, a recent report on the progress of the deal found that the reduction so far had been a quarter of that (*DDN*, May, page 4).

'Alcohol-fuelled harm costs taxpayers £21bn a year. It is therefore right that the alcohol industry is taking action to help reduce this burden, without penalising those that drink responsibly,' said home secretary Theresa May of the new arrangements. 'The government welcomes the progress the alcohol industry has made so far in responding to the challenge we set them. We now look forward to seeing the positive impact of these pledges and continuing to work with industry to explore what else can be done to tackle alcohol abuse.'

'As responsible businesses, we are determined to play our part and have set out a whole new programme of voluntary actions in response to the challenge set by the home secretary,' said Portman Group chief executive Henry Ashworth. 'Working in partnership with business is a great way to get positive change happening quickly in towns and cities throughout the UK.'

Funding fears for harm reduction

International provision of harm reduction services is under threat from a funding crisis and lack of political will, according to a report from Harm Reduction International (HRI), the International HIV/Aids Alliance and the International Drug Policy Consortium (IDPC).

Funding has been falling 'dangerously short' of estimated needs for some time and is set to deteriorate further, says the document, the result of changes in donor policies and neglect on the part of national governments. The report urges international donors, UN agencies and national governments to take action, stressing that 'there can be no "Aids-free generation" without targeted efforts with and for people who inject drugs'.

Around 40 per cent of new infections are the result of unsafe injecting practices in middle-income countries – particularly in Eastern Europe and Asia – where around three quarters of people who inject drugs live. However, changes in Global Fund funding policy 'threaten to significantly reduce' harm reduction allocations in these countries, says the report. Major international donors like the US and UK are also withdrawing aid from many of these countries because of their middle-income status. Of the 15 countries prioritised by UNAIDS for harm reduction programmes, only Kenya is still classed as a low-income country according to World Bank definitions.

'Donors are retreating from these countries under the premise that they are wealthy enough to resource their own HIV responses,' the report states. 'Yet national governments are often unwilling to invest in services for key populations, leaving existing programmes under threat and scale-up impossible.' It cites the example of Romania, where many programmes closed following the end of Global Fund support and where a subsequent rise in HIV transmission through unsafe injecting has been reported. 'Underpinning many of these resource gaps lies a fundamental inhibiting factor: harm reduction services for people who inject drugs are often politically unpopular,' it adds.

Around $2.3bn is needed next year alone to fund HIV prevention among people who inject drugs, according to UNODC estimates, but only around 7 per cent of that has been invested by international donors so far. National governments are also choosing to prioritise 'ineffective drug law enforcement' over harm reduction, even in countries with high drug-related HIV transmission rates, the report says. 'Just one tenth of one year's drug enforcement expenditure (estimated to exceed $100bn globally) would fund global HIV prevention for people who inject drugs for four years,' says HRI.

The funding crisis for harm reduction at www.ihra.net

Young drug and alcohol consumption continues to fall

Illegal drug use among secondary school pupils remains significantly lower than a decade ago, according to new figures from the government's Health and Social Care Information Centre (HSCIC).

Sixteen per cent of pupils had ever taken drugs, 11 per cent had taken them in the last year and 6 per cent in the last month, says *Smoking, drinking and drug use among young people in England in 2013*, figures similar to 2011 and 2012 but 'considerably lower' than in 2001. Pupils were more likely to have taken cannabis than any other drug.

Thirty-nine per cent had drunk alcohol at least once, but only 9 per cent in the last week, continuing a downward trend since 2003 when a quarter of pupils had done so. Among those who had drunk in the last week, the amount of units consumed was also lower than in previous years. While more than half of pupils thought it was acceptable for someone their age to try drinking and a third thought it OK to try smoking, only 9 per cent thought it was OK to try cannabis and 2 per cent cocaine. The figures are based on a survey of more than 5,000 pupils in almost 200 schools across England.

According to the *2012/13 Crime Survey for England and Wales*, 8.2 per cent of adults had taken an illicit drug (excluding mephedrone) in the last year, a fall from 8.9 per cent in 2011/12. While the proportion of 16 to 24-year-olds taking any drug in the last year was almost double the proportion in the 16 to 59 age group – at 16.3 per cent – it was still down on 19.3 per cent in 2011/12.

Meanwhile, a new Home Office report states that declining heroin and crack use over the last decade – particularly among young people – has gone hand-in-hand with lower rates of acquisitive crime. 'Studies agree that, in aggregate, heroin/crack users commit a large number of offences; large enough, this paper shows, to be an important driver of overall crime trends,' says *The heroin epidemic of the 1980s and 1990s and its effect on crime trends – then and now*.

While the number of heroin users increased substantially during the 1980s and '90s – and 'many also used crack as their drug-using career developed' – the national peak was probably between 1993 and 2000, says the document, while crime also peaked between 1993 and 1995. Previously, the rise and fall in illicit drug use had not been 'especially prominent' in the debate about crime levels in the UK, however, 'perhaps due to a lack of robust data for the whole period', it adds.

'Studies disagree about whether it is illicit drug use that causes the criminality,' says the report. 'This is because a sizable proportion of heroin/crack users do not resort to theft. And many were offending before taking these drugs. However, evidence suggests that, for at least some users, heroin/crack was the catalyst for offending, and for others it probably accelerated and extended their criminal career. Thus aggregate-level change in numbers of heroin/crack users is likely to affect crime trends.'

See news focus, page 6

Smoking, drinking and drug use among young people in England in 2013 at www.hscic.gov.uk

The heroin epidemic of the 1980s and 1990s and its effect on crime trends – then and now, and Drug misuse: findings from the 2012/13 crime survey for England and Wales at www.gov.uk

YELLOW CARD! A new resource explaining how to handle a stop and search by the police has been launched by Release. Designed in partnership with young people, the aim of the Y-Stop card is to boost confidence and provide 'tools for advice, empowerment and reporting police behaviour'. Tips offered include staying calm, maintaining eye contact and asking questions. 'Treat it as a conversation, not a confrontation,' says the card. Available to download at www.release.org.uk

NEWS IN BRIEF

STARK STATISTICS

Hospital admissions for hepatitis C-related end-stage liver disease rose to nearly 2,400 in 2012, up from just over 600 in 1998, according to new figures from Public Health England, with deaths rising from less than 100 to 428. The agency recently warned of a 'liver cancer time bomb' if levels of hep C treatment were not scaled up (*DDN*, July, page 5).

'Despite the examples of good practice and the availability of effective treatments, we must accept that the rising hospital episodes and deaths, the poor diagnosis rate and the shockingly low level of treatment means we are failing patients,' said Hepatitis C Trust chief executive Charles Gore. *Hepatitis C in the UK: 2014 report at www.gov.uk*

BENZO BENCHMARKS

New guidance on benzodiazepines for primary care professionals has been produced by SMMGP. Written by Chris Ford and Fergus Law, *Guidance for the use and reduction of misuse of benzodiazepines and other hypnotics and anxiolytics in general practice* is available free at *www.smmgp.org.uk*

ORANGE UPDATES

Public Health England is consulting on whether parts of the *2007 Drug misuse and dependence: UK guidelines on clinical management* – known as the 'orange book' – should be updated in the light of the evolving evidence base and changes in the sector such as an ageing treatment population, fewer people using heroin and increasing use of new psychoactive and performance-enhancing substances. 'An update would build upon the original version to reflect new evidence, issues and ways of working, as well as developments in the recovery orientation of drug treatment,' says PHE. *Have your say at www.gov.uk/government/consultations/drug-misuse-and-dependence-uk-guidelines-on-clinical-management until 30 September.*

STRANGE MOLECULES

A new legal high information website has been launched by CRI. *www.strangemolecules.org.uk* is aimed at young people, their families and professionals, and named to 'more accurately reflect' the nature of the drugs –'unsafe substances that can be even more dangerous than their often illicit counterparts', says CRI.

PRISON PRESUMPTIONS

A new report on the reasons behind the UK's large prison population has been published by the British Academy. *A presumption against imprisonment: social order and social values* looks at 'why we seem unable to reduce our reliance on imprisonment' and includes strategies for cutting the number of prisoners. *Available at www.britac.ac.uk*

GETTING A FIX ON FIGURES

Just how closely linked are drug misuse and acquisitive crime statistics?

'Drinking sensibly, never doing drugs – is this the age of the young puritan?' asked the *Guardian* last month. 'Why drugs are no longer cool: teenagers are internet addicts while their parents snort cocaine,' offered the *Telegraph*.

The Health and Social Care Information Centre's latest figures on falling rates of drug and drink consumption among secondary school pupils (see news story, page 5) made national headlines, just the latest of countless reports over the last few years that seem to confirm that younger people are slowly turning away from drugs – or older-established drugs anyway. While services can struggle to keep up with the growing list of new psychoactive substances, as well as higher rates of image and performance-enhancing drug use, problem heroin and crack use does seem to be increasingly confined to an older, entrenched population, many of whom started using in the 'heroin epidemic' of the 1980s when new supply routes meant more drugs coming into the country at a time of mass unemployment.

It's no secret that the dramatic increases in funding for drug services that came with the advent of the NTA was in part driven by a desire to keep a lid on crime figures, but few attempts have been made to properly map out the link between acquisitive crime rates and problem drug use until the Home Office's new report, *The heroin epidemic of the 1980s and 1990s and its effect on crime trends – then and now*.

According to the document, the national peak of the epidemic was 'probably' between 1993 and 2000, while crime peaked between 1993 and 1995. As well as a comprehensive review of existing research literature, the report used police force area-level comparisons of the 'Addicts Index' and recorded crime data from 1981 to 1996, alongside modelling the number of heroin/crack users and their offending.

The police area comparisons showed that 'different types of theft generally peaked together within an area' but 'the timing and size of these peaks varied across areas and was highly correlated with heroin use', concluding that about 40 per cent of the national rise in the highest-volume crime types – such as burglary and theft from vehicles – from 1981 to the peak could be 'attributed to rises in the number of heroin users'. The modeling approach, meanwhile, found that 'heroin/crack use could account for at least half of the rise in acquisitive crime in England and Wales to 1995 and between a quarter and a third of the fall to 2012, as the 'epidemic cohort aged, received treatment, quit illicit drug use or died'.

However, the document makes it clear that – despite the wide body of evidence drawn together by researchers – the 'hidden' nature of the study group 'means that robust data remain sparse'. The paper is also careful to stress that other factors – most obviously unemployment – also play a significant role, and while peaks in acquisitive crime levels matched the timescales of heroin epidemics in England, the US and parts of Europe, there were also regional exceptions.

The lack of high-quality data means that the fundamental questions of whether opiates/crack caused the crimes committed by the people taking them, and whether the peaks in drug use correlated with peaks in crime may never be answered 'definitively', it states. However, 'on causality, the evidence gathered here shows that opiate/crack use almost certainly generated additional offences, but quantifying this precisely remains challenging'.

The best summary, it concludes, is to demonstrate the existence of an 'epidemic narrative' that fits the facts. This is that drug epidemics produced a cohort of users, and a steady rise in crime during the 1980s – during which most of England and Wales 'remained relatively unaffected by the epidemic' – then increased 'very rapidly in the 1990s as every police force area except Merseyside reached its peak of opiate/crack use'. Then, once 'all susceptible individuals had been "exposed", the number of new users probably decreased just as quickly as it had risen' and crime fell – at first quickly as 'less-recalcitrant' users quit in large numbers, and then more slowly.

'Heroin/crack use could account for at least half of the rise in acquisitive crime in England and Wales to 1995 and between a quarter and a third of the fall to 2012.'

Home Office report: *The heroin epidemic of the 1980s and 1990s and its effect on crime trends – then and now.*

'The cohort was not homogeneous,' it states. 'Many (perhaps most) did not become either long-term addicted or prolific criminals and some were offenders before using opiates or crack. While many probably had the clustering of crime risk factors that could have marked them out for a criminal career in the absence of the epidemic, the cohort probably also included a number of individuals whose only crime risk factor was a susceptibility to peer influence at a time when heroin use was spreading in their area. For the first group, heroin use may have accelerated and extended an existing criminal career and for some of the second group heroin may have kick-started a criminal career.'

Perhaps mindful of the potential media reaction, the paper also clearly spells out that the impact was on crime volumes rather than overall harm, which is largely driven by violent and sexual offences. 'The most important caveat though, is that this narrative does not imply that opiate/crack use was the sole factor driving crime trends,' it states. 'Many factors are likely to have been important and interactions may also be crucial.'

Among the policy implications, it says, are that as the number of heroin and crack users continues to fall, it will continue to be at a relatively slow pace, as many older users will have been in and out of services for years, and 'focusing resources on the most important individuals may be the key.'

The other main policy conclusion, despite shifting drug trends, remains the importance of preventing a future epidemic, it stresses. 'Evidence shows epidemics do not strike all areas simultaneously and there is a lag between epidemic start and the moment it becomes visible on treatment or criminal justice datasets. Local-level monitoring is therefore crucial.'

Report at www.gov.uk

MEDIA SAVVY

WHO'S BEEN SAYING WHAT..?

When laws are widely flouted they cease to be laws and instead become instruments to punish certain members of society. When the government sacks its chief drugs advisor for stating scientific facts it exposes itself as arrogant and unheeding. When billions are pumped into prohibition without producing any significant reduction in drug use – during a period of austerity no less – it makes a mockery of our system of governance.
Alex Horne, *Independent*, 4 July

In the boomerang sting that stung the stinger, [Mazher] Mahmood posed as a Bollywood producer and enticed Tulisa [Contostavlos] to Las Vegas to discuss paying her £3m to star in a movie with Leonardo DiCaprio. Two minutes into the pitch, a less naive soul would have thought: "Aye, aye, it's that tosser Mazher Mahmood." ...Beyond the priestly enclave of the red-top news conference, does anyone care if a music industry twentysomething likes the odd line? Or claims, after being plied with booze, to be willing to facilitate a deal to ingratiate herself with an apparent film producer? ...Targeting a vulnerable young woman with the intent to destroy her is a deeply despicable act of bullying.
Matthew Norman, *Independent*, 22 July

Failed relationships, aspirations not achieved, mental breakdown, poverty, unhappiness, alcoholism, drug addiction. All of that the consequence of someone having behaved badly towards them several decades before. Maybe put a hand on their thigh. Maybe worse. And you dare not gainsay these furious litanies of complaint, because if you do then you are in some way complicit. It is a bizarre state of mind, in my opinion, that enables normally rational people to swallow this paradigm – the official paradigm now – whole, and does not question it at all, just accepts it as fact.
Rod Liddle, *Spectator*, 12 July

We must challenge those who label drug addicts as weak. Only then can we call ourselves a compassionate society.
Liz Macdonald, *Guardian*, 24 July

A judge has ruled that an American drugs dealer [Johnny Callie] can't be deported from Britain because he has a 'human right' to free medical treatment on the NHS... Callie's case was bolstered by a supportive letter from the Norfolk and Suffolk Probation Trust. There's a surprise. The *Guardianistas* who run the probation service would consider Callie a valued 'client'. The interests of the wider public are never taken into consideration.
Richard Littlejohn, *Mail*, 15 July

It would be hard to imagine a less deserving case for free healthcare than Callie, a US citizen who was jailed in 2007 for supplying heroin and cocaine. I am sorry that he is said to be depressed and to suffer from diabetes and high blood pressure, but he was part of a trade which has inflicted far more misery and ill health on others. Rather than treat him for free, logically Britain should send him a large bill not just for his own treatment but to cover the treatment the NHS has provided for the drug users who bought the heroin and cocaine he supplied.
Ross Clark, *Express*, 15 July

ENTERPRISE CORNER

MIND THE GAP

Employability support should be an important part of tackling reoffending rates, says **Amar Lodhia**

LAST MONTH I WAS INVITED to take part in a 'MOPAC Challenge', a regular deep dive into one aspect of criminal justice conducted by London's deputy mayor for policing and crime, Stephen Greenhalgh. Held at City Hall, this particular MOPAC Challenge focused on substance misuse; I was representing the charity sector alongside Addaction. We were joined by senior officials from the NHS, local authority community safety teams and, of course, the Metropolitan Police service.

During the session, we reiterated our belief – which we've made in this column many times – that employment and self-employment work. I also spoke about the natural entrepreneurial flair in many of the people we encounter and how this needs to be channelled into something positive for the individual and for society.

But our key point, which I'm glad was supported by other participants at the challenge, was to identify a gap in the provision and resourcing of employability skills in the Integrated Offender Management (IOM) teams with local crime fighting forces. These are multi-agency hubs, run by the police, looking to bring together a wide range of organisations to help tackle the most prolific of reoffenders, up to a third of whom also have substance misuse issues. However, we've found that employability support and promoting self-employment is one area that, in most cases, is missing from these IOM hubs – support that we know can help reduce the rates of reoffending and substance misuse.

Of course, having identified the gap, the challenge now is how to fill it. It's an area that we know the deputy mayor took on board as one of his three actions from the session, and which we hope to be supporting him on, given our experience.

In fact, this is the gap that we are hoping to fill in West Yorkshire. We recently visited three major IOM hubs there as a part of our planning for an innovative service to reduce crime and drug-related crime in the region. These Integrated Offender Management teams were some of the first to be set up anywhere in the country and have been having a real impact in reducing the levels of reoffending. The visit confirmed everything we'd been saying about a gap, but they also reminded us how we can achieve so much more when agencies and organisations work together.

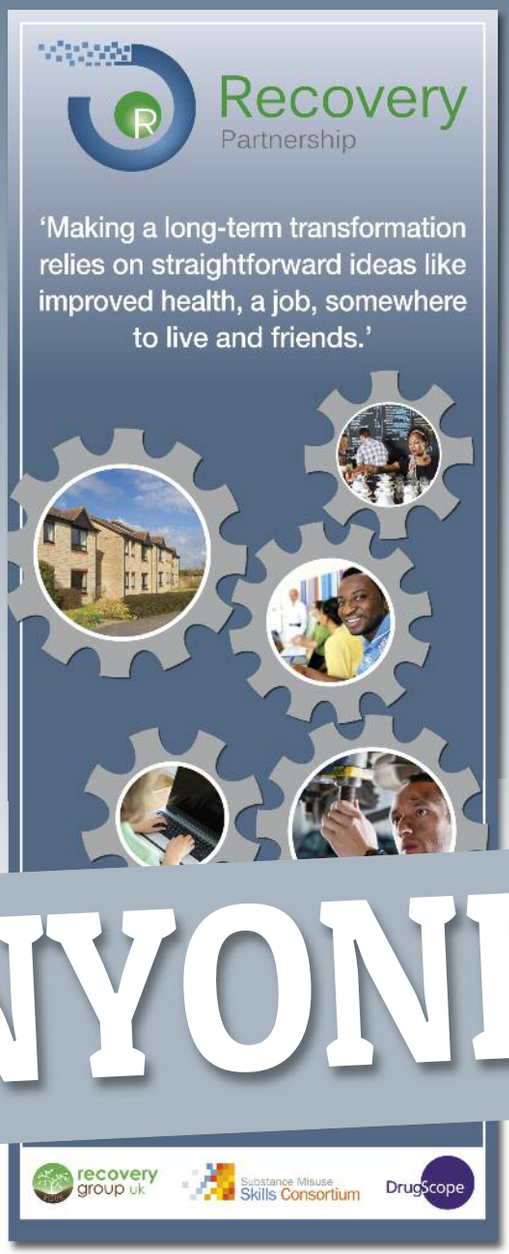
How to get these smaller organisations and charities working and delivering in the public sector, in the face of competition from far larger organisations, is an issue that will exist at least until the general election next year. The shadow social enterprise minister, Chi Onwurah, announced that a Labour government would offer some government contracts that only not-for-profit organisations could bid for. Following one of the biggest shake-ups in government since the 1960s, the departing minister for civil society, Nick Hurd, urged the prime minister to do more to enable small charities and social enterprises to win public contracts. As we get closer to May 2015, I hope we'll hear a lot more from all the political parties on this subject, but I'm keen to get your thoughts as well.

To enquire more about our work, please contact me at amar@tsbccic.org.uk and follow me on Twitter @amarlodhia or @tsbclondon. Don't forget to use the #tag DDNews when tweeting!

Amar Lodhia is chief executive of The Small Business Consultancy CIC (TSBC), thesmallbusinessconsultancy.co.uk

Decent long-term housing has been identified as one of the biggest determinants of recovery, so how can we address a critical lack of provision? DDN **reports from last month's Recovery Festival**

THE RECOVERY FESTIVAL 2014
talent • ambition • opportunity



'Housing and employment are at the core of recovery... We need to respond to new challenges with resilience'

MARCUS ROBERTS

IS ANYONE IN?

Housing and employment are at the core of recovery, said Marcus Roberts, chief executive of DrugScope, referring to the charity's *State of the sector* report. But there were significant challenges. It was not just about the availability of housing, but also the quality. There were significant gaps in housing and housing support, with a distinct lack of suitable accommodation for people still using drugs.

Localism had given local authorities more discretion, so it was important for the substance misuse sector to make its case, said Roberts. 'We need to respond to the new challenges with resilience,' he said. While the squeeze on local funding was painful, it should also make us 'think more creatively, with energy and passion'.

There was a lot going on that we could learn from, he said, including the Chartered Institute of Housing's compendium of good practice and St Mungo's Broadway's (SMB) report on the needs of homeless women.

But we needed to fight to maintain a skill base and the 'multiplicity of people's needs should be a starting point to rally around'. It was a 'critical time of challenge, but also of opportunity,' he said.

Bill Randall, chair of Brighton and Hove City Council's housing committee, shared his experiences of a densely populated city that had 'an enormous problem with space for housing', where local landlords were increasingly reluctant to take people on housing benefit. The city had 2,000 heroin and cocaine users and although drug-related deaths were now falling, it had had the unenviable title of being 'the drugs death capital of Britain' for some time.

'A real spirit of partnership' had been key to changing the city's approach to drug and alcohol problems, pulling together housing providers, public services, the voluntary sector, faith groups and other organisations. Pooling budgets to make the most of diminishing resources was a constant challenge, but 'returning public health to local government has been critical to changing what we're doing,' said Randall.

With much of Brighton's housing allocated to market rent, shared ownership or sale, imaginative solutions had been needed to help the city's most vulnerable. One such example was Brighton Housing Trust (BHT)'s scheme of container homes, shipped from Holland, which were of a much higher standard than some of the existing private rented sector.

'The idea is that you have a pathway from the street into supported housing and then into independent housing,' said Randall. 'What you can't do is put people in mainstream housing and leave them there, which has happened in the past with disastrous effects,' he added. 'As someone said at a recent tenants' meeting, if you put a vulnerable tenant in a block of flats and don't support them, you make every other tenant vulnerable.'

The value of partnerships was underlined by Ron Dougan, chief executive of Trent and Dove Housing, who pointed out that 'the media love nothing better than to give bad news stories about housing associations and their tenants', highlighting anti-social behaviour stories as front page news. He admitted that he had himself 'not been hugely keen

'People we house through BAC have a far greater rate of successful tenancies.'

RON DOUGAN

'We really want people to be able to move on...'

AMY WEBB

'Short tenancies... no hassle to landlords as they know they'll get the rent'

SUSAN FALLIS

'Thames Reach's solutions include a shared housing model with an employment focus.'

JEREMY SWAIN

to welcome the people that had come through this particular route into our homes.'

His attitude had been changed through a 'proper partnership' with the BAC O'Connor, which involved intensive pre-tenancy work.

'We understand the person and what their needs are,' he said. 'We give them just the right amount of support to sustain their tenancy and support them into the community.' This support extended beyond housing to mobility, mental health, addiction – 'the whole gamut of problems'. And progress had been encouraging: 'people we house through BAC have a far greater rate of successful tenancies,' he said, which made a strong case for housing authorities homing people who had come through the recovery route.

People needed three basic things, he said: a decent home in the right area, continued support including a network of family and friends, and something decent and permanent to do.

*****

Susan Fallis, director of Real Lettings, shared an innovative scheme from St Mungo's Broadway, which helped homeless people to move into the private rented sector while reducing the risks for landlords. It was a simple model, with SMB leasing the property for three to five years, maintaining it, and effectively becoming the tenant.

The short tenancies were 'no hassle to landlords as they know they'll get the rent' and a sustainable business model for SMB. Landlords were charged 17.5 per cent of the local housing allowance as a management charge, which paid for the cost of managing and maintaining the property.

There was a tight arrears procedure, with tenants being contacted as soon as they missed one payment, but the links with support services meant it was all about tenant sustainment, further enhanced by helping them to gain skills for employment and volunteering.

But things had changed over the last two years as 'property procurement became a nightmare'. The Local Housing Allowance (LHA) had been capped at 1 per cent, deterring landlords who were relying on a rent increase. The solution was to get people to invest in properties, for an anticipated 20 per cent return.

SMB found a fund manager, the Real Lettings Property Fund, a private rented sector investment fund delivering commercial returns. It was the first property fund in the UK to buy accommodation to support homeless people, and 'it was not just about the rent to them, it was a true partnership,' said Fallis.

The aim was to get £45m investment to purchase at least 240 one and two-bed homes in London, near to public transport and amenities. With The Esmée Fairbairn Foundation as the first investor, others were following.

All of this showed what a small social enterprise could achieve in this sector, opening the doorway to procuring large numbers of private rented properties, said Amy Webb, SMB's Real Lettings manager. This model represented a bridge between the private rental model and services, she said.

While the private rented model was a viable option for vulnerable people, it was essential to have the right kind of support available so they could sustain their tenancies.

'We're not support workers, we're a landlord – but we can create a system where we can provide practical advice and support around how that person is performing in their tenancy,' she said.

Part of the support entailed taking risk. Rules had been changed so that the tenant could be evicted after 12 months rather than just six, and they no longer had 20-page assessment forms. Instead, the tenant needed to commit to having 'milestones of engagement' in a very proactive style of rent management. Rent officers aimed not to 'harangue', but opened doors to sources of advice.

'We really want people to be able to move on,' said Webb. 'Real Lettings isn't the end of the road – it's a chance to prove you can develop a rent history and hold down a tenancy.'

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The long association between the worlds of homelessness and recovery meant there were many opportunities for organisations to work collaboratively together, said Thames Reach chief executive Jeremy Swain.

Dealing with a 'homelessness backlog', created by the housing shortage, required creative solutions. Thames Reach's solutions included a shared housing model with an employment focus, which was supported by social investors. Three people lived in a shared house, with one of the residents given a special role as peer landlord, offering support to others on issues around housing and employment and 'making shared housing into something beneficial', according to Swain. With the money from investors, the housing could be offered at below-market rent.

Other housing schemes were creating 'a realistic package of support', such as Thames Reach's partnership with the local authority in Greenwich, CRI and South London and Maudsley NHS Foundation. Another partnership with Vision Housing was enabling Thames Reach to refer rough sleepers into self-contained accommodation, an initiative funded by a social impact bond.

Swain also outlined the benefits of the Housing First model, accepted in the US as the best way of helping people off the street. Unlike many of the housing schemes this model relied on harm reduction rather than the requirement of abstinence, but achieved positive outcomes through linking with

"The model isn't the bricks and mortar – it's the process of making sure people have what they need.'

KAREN BIGGS

long-term multi-agency support.

Housing was an important element to sustaining the recovery model, said Karen Biggs, chief executive of Phoenix Futures – a housing association as well as a treatment provider.

'The model isn't the bricks and mortar – it's the process of making sure people have what they need,' she said. The power of communities played a huge part in that, with meaningful interaction and relationships a vital part of 'recovery capital'.

A snapshot of Phoenix service users showed that 21 per cent had been homeless, 6 per cent were in full-time employment and 25 per cent had been in care (compared to just 1 per cent of the general population).

Interventions were vital, as service users tended to think they could have little impact over changing their lives. But alongside treatment, it was important to increase 'personal recovery capital' through building a sense of optimism, 'social recovery capital' through valuing the importance of relationships, and 'collective recovery capital' through realising 'the impact of good quality, decent housing that shows that we value people in recovery.'

The organisation had developed 'Phoenix Plus' models as a way of taking treatment gains beyond the treatment setting, an initiative that was supported by 'an army' of housing associations.

'The housing model is the process – it's not the physical environment someone goes into, it's not the tenancy that they're issued, nor their landlord,' said Biggs. 'It's the process of ensuring that there are appropriate pathways to align what people need with their recovery journey.'

There were plenty of barriers to overcome, such as funding cuts and benefit changes. 'But there's an opportunity to work together to create recovery communities to take us past bricks and mortar,' she said. **DDN**

OVER TO YOU...

Journalist and Brighton councillor **Bill Randall** chaired an expert panel, with contributions from the floor

HOW CAN WE WORK BETTER WITH PRIVATE LANDLORDS?

'Each landlord is different, and that's part of the biggest challenge. There are many different types of landlords and many different types of businesses. You're dealing with hundreds of small businesses in one area, and that's very complicated for many councils to understand because they want one person to deal with. Having to deal with lots of small businesses is quite complicated and takes a lot of work.' ***Gavin Dick, National Landlords Association***

'When we were doing the *State of the sector*, we found numerous examples of good partnership working between landlords and treatment providers. They all fell into two or three categories. Some happened by chance. In other cases, there was a local landlord who had some experience of, or sympathy for, substance misuse and treatment, then worked with other landlords to build relationships. Finally, some examples had been brokered by positive local authorities and other organisations who had gone out and made contact with their local landlords and built relationships with them.' ***Paul Anders, DrugScope***

HOW CAN WE MITIGATE THE IMPLICATIONS OF UNIVERSAL CREDIT?

'DWP recognises that some people in receipt of universal credit may need additional help to make and manage their payment of universal credit. We have been working very closely with local authorities to provide a support services framework (published in 2013), to support people who need extra help. The framework promotes partnership working between DWP and local authorities as well as housing and voluntary sectors. The general idea is that these partners working together actually provide a service to help with budgets and can allow payments to be made directly to landlords.' ***Izzie Pragnell, Department for Work and Pensions (DWP)***

'We have been working very closely with local authorities to provide a support services framework.'

IZZIE PRAGNELL

WITH SUPPORTING PEOPLE BUDGETS NO LONGER RING-FENCED, WHAT DOES THE FUTURE HOLD?

'Brighton and Hove have completely protected the supporting people budget. In some places it has been absolutely decimated.' ***Bill Randall, chair***

'There is hope – new models are being put into place.' ***Paul Anders, DrugScope***

SHOULD HOUSING FIRST MEAN 'HOUSING BEFORE TREATMENT'?

'There's a risk that Housing First is becoming "housing only" and that would be a very grave mistake. Having the support is vital.' ***Paul Anders, DrugScope***

'There's very much an ideological stance behind Housing First. But it's important to consider those who won't embrace treatment and their right to basic human rights around housing, regardless of whether they embrace recovery. Good housing, wherever possible, should be a basic human right.' ***Alex Boyt, user involvement coordinator***

'Local councils need to look at the community and the bigger picture before rehousing people. In most situations, the policies are not thought through. Local councils need the courage to actually engage and do something about the housing problems in their area.' ***Gavin Dick, NLA***

LETTERS

'Advocacy is an art. Caroline had this in bucket-loads and was respected by service users. Her work was grounded in service users' own experience – while reminding them of their responsibilities.'

VITAL LEGACY

Caroline Blackburn's obituary (*DDN*, July, page 10) captures her passion for service user work. Yet other things need to be mentioned.

Advocacy and peer-based work are very much needed today. With resources increasingly under pressure, independent advocacy may be seen as an unaffordable luxury. However, conflicts frequently occur between service users and professionals in addiction treatment. Some remain unresolved – through impasse, drift, unnecessarily bureaucratic pathways/criteria, clinically imposed decisions, communication breakdown or lack of confidence among service users to broach their true feelings about their treatment.

Such situations will invariably impact negatively on people's recovery and the overall effectiveness of resources. They only become visible if managers acknowledge that fallibility in treatment conversations is not limited to patients, and invest in independent ways of capturing, counting, expressing and making sure that such issues are present, supported, and understood as a wider measure for service improvement. Some localities did this.

Advocacy is an art. Caroline had this in bucket-loads and was respected by service users. Her work was grounded in service users' own experience – while reminding them of their responsibilities. It is a pity that in these hard times, this approach is rarely seen. Perhaps this may not be because of the case for such work, but rather, unwillingness in localities to face up to uncomfortable truths. Equally though, a lack of capable leaders of service user organisations makes life easy for some to portray everything as rosy.

Caroline was deeply respected. Those close to her understood that she helped change numerous lives for the better. She was a qualified counsellor, and a committed advocate. Readers should perhaps recognise this by critically reflecting on present provision, and continue asking ourselves this important question: Who now independently engages with individual service users' views about their treatment, and advocates for them – regardless of their treatment goals?

Name and address supplied

RADICAL TALK

A couple of years ago I wrote a blog article about the strained relationship between radical politics and drug dependency. I was reminded of this blog on reading Alistair Sinclair's excellent article 'Catching the Wave' (*DDN*, July, page 8).

A bit that I find fascinating is the line 'we have been discouraged… from looking at the mine itself.' Discouraged by whom, and why?

Sinclair's article talks with the passion of a fin de siècle theorist of how we are 'staring in to an abyss and facing the challenges of modernity'. Radical talk indeed. Almost revolutionary. How well does such radicalism sit alongside 12-step traditions?

While the spaces that the recovery community creates may themselves be apolitical, they are unavoidably located within a wider political context. The political idealism which has driven much of what is now labelled 'recovery' has very definite views of canaries and mines and recovery. Once recovered, a canary should very much get itself back down the mine, and become a hard-working canary, especially if it wants any more millet.

Far from critically looking at the society that creates the sickness, the political paymasters are disinterested in healing a sick society rooted in inequality. They want the sick well so that they can go back to being efficient healthy cogs in the machine, but with an adjusted mind-set that allows them to cope with the machine better, in gratitude and humility.

Extracted from 'Old waves, new waves, permanent waves' on the KFX drugs blog at www.kfx.org.uk

NO QUICK FIX

Alistair Sinclair makes an interesting analogy about society's casualties, as canaries in the mine, in his article 'Catching the Wave'. His idea of looking at the mine itself is bold, even revolutionary in its ambition. In the meantime the widely held therapeutic approach of fixing such casualties and returning them to productive life needs to be challenged for other reasons.

Many, if not most, problem substance users never had a productive life to return to. Similarly this also applies to concepts of rehabilitation as it implies that such people were habilitated before their problems began.

So rather than seeking to return these damaged people to productive lives or re-habilitating them, a different approach is needed. Better to begin working with the recognition that they lack important life and social skills, having never known or learned them in their young lives. An assumption that they previously knew how to manage in our 'sick nation' or were somehow previously productive is to miss a trick and overlook key deficits, which are maybe why they became 'canaries' in the first place.

The role of canaries has been phased out by different and changing approaches; therapeutic recovery approaches may need to begin from a different place.

Andy Ashenhurst, Canterbury

THE WAY FORWARD

As an ex-drug worker I used to constantly believe in all of this ('The Buddhist Way', *DDN*, July, page 13). Unfortunately the best I got out of my agency was to allow yoga once a week, which in itself was amazing for the clients but not enough. Let's hope this is the true way forward.

Becky

On *The Buddhist way*, July 2014, from www.drinkanddrugsnews.com

GET INVOLVED!

Consultation is now active for *DDN*'s annual service user conference, with a steering group meeting taking place in September. We want your ideas on the programme and suggestions for speakers. Never has true SU involvement been more vital and we need to make sure the conference addresses your concerns and reflects your priorities.

Please visit www.drinkanddrugsnews.com and click on the SU conference button

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity – please limit submissions to 350 words.

Right to

With family planning a sensitive and controversial subject, the sexual health needs of service users can be overlooked. **Rosie Mundt-Leach** tells DDN how a south London drug service has teamed up with commissioners and sexual health experts to offer open in-house clinics, with promising results

The pain of a pregnancy ending in a baby being removed into care immediately after birth is one of the most distressing experiences known to those involved in drug and alcohol treatment – yet it is all too familiar to drug and alcohol service users, their families and clinical staff. When it has happened once to an individual woman, it is more likely to happen again when another pregnancy occurs – often very soon after the first removal, and with no time to achieve stability before the mother is once again traumatised and demoralised even further.

The *Hidden harm* report (2003) recommended that contraceptive services should be provided through specialist drug agencies, but this has not happened in practice. Staff at South London and Maudsley NHS Trust (SLaM) addiction services approached colleagues in Guy's and St Thomas' NHS Foundation Trust (GSTT) community sexual health and asked for help to make contraception available to women with substance problems, while enabling them to retain their fertility and have the best possible chance of successfully conceiving and keeping their children when their recovery was secure. Two years later, we can evaluate the success of this joint working and look at further ways to help marginalised people gain access to sexual health services.

An audit in 2012 showed high levels of unmet need for contraception among women using SLaM addiction services. Sexually active women said they were worried about pregnancy, but were not using contraception. In April 2013, using one-off start-up funding provided by Southwark drug and alcohol commissioners, an agreement was reached that the consultant in community sexual health and HIV from GSTT together with our already established BBV nurse would start providing health care on drug service premises.

Due to administrative delays, direct work with patients did not start until June. While waiting, links were made with a brand new, fully equipped, sexual health clinic just ten minutes' walk from the Southwark community drug and alcohol team (SCDAT) base. Staff at SCDAT visited this clinic and actively informed service users about it. Privileged access was provided so there would be no need for appointments and no queuing, but even so, only one person per month used this opportunity, demonstrating that an in-house service might be more effective.

In June 2013, the in-house clinic opened for four hours per week, backed up by some additional visits outside clinic hours when SCDAT service users asked to see the sexual health consultant. There have now been 52 clinic sessions and a total of 184 consultations; 43 individual men and 74 women have received services. Some people have come with a partner (both different sex and same sex), many have come on their own, and often introductions have been made by their key worker.

A total of 74 sexually transmitted infection (STI) screens have been carried out and 67 BBV (including HIV) screens. Treatments for STIs have been started and/or completed and the risk of transmission has been eliminated. Twenty-five women have received (often long overdue) cervical smears. Investigations of incontinence, sexual dysfunction, and prostate cancer have been carried out, and concerns about sexual abuse, sexual assault, intimate partner violence, and infertility have been raised and suitable referrals made.

Long acting reversible contraception (LARC) gives drug and alcohol dependent women the opportunity to delay pregnancy while establishing their recovery. If the woman chooses to stop the method it is removed and fertility is restored – she doesn't have to give a reason for asking for removal, this is done immediately, at any time, on request without question. The hormonal contraceptive Depo-Provera (depot medroxyprogesterone acetate, or DMPA) is an exception to this, as the 12-week injection itself cannot be reversed and there can be a delay before fertility resumes once the method is stopped; this is always explained before a woman chooses this method. None of the LARC methods prevent STI transmission, and none are prone to failure due to user error as is the case with oral contraceptive pills and condoms.

Data shows that individuals using the clinic represent service users with the most complex needs and the most severe poly-drug and alcohol dependency. This demonstrates that the clinic is meeting the needs of drug and alcohol users who would not otherwise attend any sexual health service, and is not just being used as an alternative to mainstream services by people who have milder addiction problems. Women were more heavily represented in the group using the service, although they only make up one third of the CDAT population, so we are satisfied that they are gaining more than fair access to the provision that they need.

The average number of consultations per clinic session is 3.5, leaving room for more, and we have provided contingency management to increase uptake. Small value shopping vouchers of £2 have been offered to people for having an STI screen and £5 for those having a LARC method or a cervical screen. This gained ethical approval and is in line with local policy for incentivising BBV screening and vaccination. The sums were deliberately kept small in order not to bring undue influence to bear on decision making.

We believe that the most important factor influencing attendance at the clinic is accessibility and also providing additional training to drug service key workers

to enable them to become more confident in recognising unmet sexual/reproductive health needs and to talk in more depth about options.

We opened a subsidiary clinic in another smaller agency run by Blenheim that is also part of Southwark Treatment and Recovery Partnership. However, we found that the uptake was low, so this was suspended. All service users from any drug/alcohol treatment agency in the borough are invited to use the clinic at SCDAT, so nobody is excluded.

Both sides of the professional partnership have learned valuable lessons from one another and from the service users' reactions to the new service. The addiction staff group was originally focused on contraception, but soon realised the huge benefits to patients of a full sexual and reproductive health service provision, including STI screening and treatment, initial management of sexual dysfunction, genital skin problems, cervical screening, initial management for fertility and menstrual and bladder problems.

The sexual health staff found how closely addiction staff work with service users and how fundamental the key worker relationship is to enabling people to take up healthcare. Simply placing a sexual health clinic in the drug service would not have worked – the partnership between staff, service users, reception staff and peer mentors was vital to the project being accepted and used. The most important factors in overcoming reluctance to attend the clinic were the expertise of the staff and word of mouth that the treatment was quick, painless and empathetic.

Working with drug or alcohol dependence provides technical challenges for clinical staff, which this approach has succeeded in addressing. Firstly, our BBV nurse who supports the clinic has a local reputation for expert blood taking skills, so blood tests are done quickly even for people with very poor veins, and everyone knows they have nothing to fear. This facilitates STI screens and liver tests.

Secondly, liver damage is a relative risk factor that has to be assessed when providing most prescribed contraceptive methods. Having a consultant-level clinician available to assess that risk is an efficient way of safely establishing the options that are available to the woman concerned and confidently helping her to decide how she wishes to proceed.

The host drug/alcohol service needs a relatively high level of daily visits to make adequate use of the time of the specialist service providers. Even though numbers seen in our service have been relatively low each week compared to mainstream sexual health services, the positive impact is disproportionately high. Undetected and untreated STIs, incontinence suffered in silence, hidden sexual dysfunction and worries about cancer are bad enough, but the human and financial costs of an unplanned pregnancy where a baby will be placed in care (care proceedings alone cost £25,000 per child) are devastating. We believe that we have found a way of addressing these issues by providing an in-house reproductive and sexual health clinic.

Sexual health staff found how closely addiction staff work with service users and how fundamental the key worker relationship is to enabling people to take up healthcare...

We were delighted that the clinic won the 2013 David Bromham Memorial Award from the Royal College of Obstetricians and Gynaecologists' faculty of sexual and reproductive health in recognition of innovative sexual health practice. We are now looking at developing our approach in other drug services and we are also considering the implications of what we have learned for people with mental health problems and for other socially disadvantaged people who may be at risk of exploitation or unplanned pregnancy with a high risk of repeat removals of children into the social care system.

Rosie Mundt-Leach is head of nursing for the Addictions Clinical Academic Group, South London and Maudsley NHS Foundation Trust.

Reintroducing people to stable employment and supporting them in the workplace are challenges that can be met with the right policies and culture – and a dash of inspiration, heard delegates at the recent Recovery Festival. DDN **reports**

THE RECOVERY FESTIVAL 2014
talent • ambition • opportunity

'We're a social enterprise with an ethos of helping and supporting... how can we join up a network of social enterprises?'

SELINA DOUGLAS

'This work has a value. It provides a lifeline...'

ALAN BUTLER

'It's important to try to learn together'

ANNETTE DALE-PERERA

STEP BY STEP

'How can we get employment at the heart of our services,' asked Selina Douglas, managing director of substance misuse and offending at Turning Point. 'We're a social enterprise with an ethos of helping and supporting,' she said. 'So how can we join up a network of social enterprises? Let's get some energy behind it.'

There were many questions surrounding barriers to employment. 'How do we give people hope that there's employment at the end of this?' she asked. 'How can we make sure frontline staff are positive and motivated? How can we make partnerships real and get people into employment?'

The reality of the sector was that we were being asked to do more for less, but partnerships – such as those with colleges, training providers and the job centre – were more important than ever.

Turning Point's 'Back in Business' model involved talking to people about their aspirations and how to reach them, and included looking at life skills, literacy and IT, as well as offering trial interviews.

'It's important we talk about these small goals and steps,' said Douglas. Turning Point was also keen to 'help social enterprises to stand on their own two feet', and had been working with Business in the Community to build relationships with local business and tackle stigma in the workforce.

Central and North West London NHS Foundation Trust (CNWL) had created a peer support network to bring 'experts by experience' into the workplace, said Annette Dale-Perera, strategic director of addiction and offender care at CNWL. Co-presenting with Alan Butler, who was a peer support worker at the Max Glatt Unit, an inpatient detox facility for drug and alcohol addiction, she explained that the success of such schemes depended on thorough preparation with the staff teams, getting them used to recovery-orientated approaches.

'We rewrote policies and renewed support mechanisms – this is a learning experience,' she said. Supervision, support and training days for the new recruits were enhanced by 'giving them time and space where they owned the environment and when they shared it with staff,' she said. 'It's about respect.'

While CNWL were 'very active on keeping staff and experts by experience happy', through encouraging them to be healthy and active and explore the 'five ways to wellbeing', she was realistic that people did sometimes relapse and 'fall over'. Alongside having robust support systems in place, she said, it was important to 'try to learn together'.

Having 'lived in addiction for three decades', Alan Butler was driven by wanting to use his experience to help others.

'I came to the unit and wanted to give my lived experience to the patients who were suffering,' he said. 'But I didn't realise how much my experience would benefit the staff, giving them insights they'd never had before.'

Arguing his case to stay at the unit at first (because of the perceived risks to his own wellbeing), the value of his work was quickly recognised and valued.

'A gambling man wouldn't have put a pound on my recovery, yet here I am. I would say to patients that if it's possible for me, it's possible for them. I'm just a bog-standard addict,' he said. 'This work has a value. It provides a lifeline that's vital.'

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'How do we get to people before they get to chaos?' asked Martin Blakebrough, chief executive of the Kaleidoscope Project, who presented with his colleague Rondine Molinaro.

Blakebrough described Kaleidoscope's partnership with Tata Steel, one of the biggest employers in South Wales, which involved helping them to review their

drug and alcohol policy and realise that it should be dealt with as a safeguarding issue for people involved in dangerous work.

The skill base of the drug and alcohol workforce could also bring value to many other businesses, he said, such as helping retailers to train security staff in drug awareness. Skills were also useful in helping businesses to reduce stigma and address prejudice that often stood in the way of treatment.

Molinaro ran a peer mentoring service that was targeted on employability. Initiatives included a partnership with Railtrack and a scheme at Prescoed Open Prison, helping prisoners to get references and gain qualifications and work experience.

'The mainstream media don't talk about partnership stories, such as The Hub, a volunteer-run café,' she said. 'But I'm in recovery myself and I truly believe that finding a job saved my life.'

Peer mentoring services, such as 'Change Step' for military veterans and those from the emergency services, were proving to be an effective way of supporting people in the workplace – and a way to 'save a lot of money for the NHS', according to Blakebrough.

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Catherine Sermon of Business in the Community (BITC) explained a campaign called 'Ban the Box!', which looked to change criminal record disclosure policy – the tick box on application forms – in a bid to create fair opportunities for people with conviction to compete for a job (*DDN*, June, page 8).

'We're not asking to ban disclosure, just delay it,' she said. 'We're forcing people to scratch their heads.'

One of the catalysts had been her own organisation's difficulty in getting clients on employment placements: 'We thought, if we're struggling, what are the chances for everyone else?'

BITC also ran a programme called 'Ready for Work', which helped around 700 disadvantaged people a year to find work, many of whom had had drug and alcohol dependency and convictions. 'It's all about challenging stigma,' she said.

Philip Richards, senior partner in major law firm Freshfields Bruckhaus Deringer, demonstrated the scheme in action, by explaining how the company signed up to the Ready for Work programme and offered 25-30 places a year.

'You can't work as a lawyer with a conviction, but there were lots of opportunities for support staff,' he said. 'At first we bottled it – we thought the lawyers wouldn't like it. But the numbers of people going back into jail is a national disgrace, so we asked ourselves whether people could come and do work placements with us.'

Realising they needed help with considering the risks, they talked to probation officers and decisions were made by the company's global HR. But once the scheme started, 'the clients have been great – committed, energetic and employable,' he said. 'When Business in the Community started "Ban the Box" it wasn't a difficult decision.'

'This is a huge problem and we can't make a difference on our own,' he added, urging delegates to think about the influence big national companies and public sector employees could have. 'We need to get the word out.'

Lester Morse and Dan Farnham from East Coast Recovery gave a perspective of how they, as treatment providers and a recovery community, were making clients 'work-ready'.

'We're more than a rehab – we try to create spaces,' said Morse. 'We create lots of projects and keep it as close to real living as possible to get the foundations in place.'

Farnham described how East Coast Recovery's range of opportunities, such as their woodworking business, were investing in the recovery of their employees. Together with the education programme, they were making sure people were leaving with the skills necessary to get a job.

Don Shenker, director and founder of the Alcohol Health Network, brought a much-needed perspective on reducing alcohol in the workplace.

'Most of the population are rubbish at working out how much they drink,' he said. 'We are trying to work with the people who are in work but drinking at too high levels.'

Drinking at these levels could have a serious impact on work performance. 'Our intention is to support people at a much earlier stage,' he said.

The aim was to work proactively and preventatively in all sorts of ways, rather than reactively, signposting them to support and linking them to local services.

'But are there other ways we can engage with people we know are stuck,' he asked. 'We want to engage the recovery community to bring in expertise. Come and speak to us – we want to find a way of joining the dots together and supporting people in work.' **DDN**

OVER TO YOU...

BBC broadcaster **Edward Stourton** chaired an expert panel, with contributions from the floor

IS VOLUNTEERING VIABLE?

'Volunteering is really key... employees need to be as clear as possible about working requirements.' ***Don Shenker, Alcohol Health Network***

'I was petrified of doing "normal things", like going into a shop and buying a newspaper. People don't get that – it's a petrifying world. If you're taking on volunteers, it's important to have structure and support... but sometimes it's the little things that are important as well.' ***Richard Maunders, UKRF***

'There are two problems with volunteering – the first is that you'll give people the impression you'll give them a job at the end of it when you can't. The second is that some employees now see themselves above volunteers. We need to break down the hierarchy.' ***Martin Blakebrough, Kaleidoscope***

'After 17 years in recovery, I've been professionalised. I felt better when I was a volunteer – I felt like I was giving. There should be routes to both choices.' ***Ashley Gibson, The Basement Recovery Project***

'How about professionalising and training people rather than just calling them volunteers?' ***Andy Stonard, Esprit de Bois***

'Part of the problem is that the conditionality regime doesn't necessarily support volunteering. It's important to have a clearer, more consistent message across the board.' ***Paul Anders, DrugScope***

HOW CAN EMPLOYERS BE MORE SUPPORTIVE?

'It's about having a conversation with people and having appropriate supervision. Learn from your own experience and empathise with other people.' ***Martin Blakebrough, Kaleidoscope***

'Make companies aware that there are different types of issues with problem drinking. Employers have a duty of care.' ***Don Shenker, AHN***

'I'm a service user and I come from a corporate environment. It's dog eat dog out there, so the last thing we were there to do was talk about problems. It was a liberating experience to ask for help; it takes strength to do that. The corporate attitude is all about going on the piss.' ***Delegate***

The UK Recovery Festival was organised by *DDN* on behalf of The Recovery Partnership, with the aim of creating a dialogue between the treatment, housing and employment sectors. ***Full reports at www.drinkanddrugsnews.com***

The realms of POSSIBILITY

Sunny Dhadley talks to **David Gilliver** about peer mentoring, raising awareness and the importance of seizing the moment

'Anything's possible if you make the most of your opportunities,' says Sunny Dhadley, service user involvement officer at SUIT and director of the Recovery Foundation CIC in Wolverhampton. 'Or create opportunities if they're not available.'

He first entered treatment at 19, the beginning of a long period of being 'in and out' of services, he says. 'Once I started using heroin and crack cocaine it was initially a matter of me saying, "I can stop if I want to stop" but it soon became apparent that it wasn't going to be that straightforward. I thought my life would still work out the way I wanted it to, but I was constantly being pulled back by my addiction – I had traits of my previous life that were apparent within my treatment journey.'

He finally completed his detox eight days before his wedding day in 2007, which was also his 27th birthday, leaving him drug-free but unsure of what to do next. 'I didn't know who I was or what I enjoyed doing,' he says.

One thing he did know was that he wanted to try to 'influence other people not to go down the same road', and decided to get involved in volunteering. 'I had to find out about it myself – I had no guidance in terms of someone saying, "do this course" or "go and see these people" – and within quite a short time I found myself managing the organisation that I'd started volunteering at.'

That was Wolverhampton's SUIT (Service User Involvement Team), which originally launched with just two staff and one volunteer. 'It was in its embryonic stage really when I took over, so I kind of had a blank canvas, other than contractual obligations,' he says. 'The service developed very much as a result of the needs and wants of the service user population.'

As well as his role as service user involvement officer with SUIT, he also set up the Recovery Foundation last year. 'SUIT sits within an infrastructure organisation – which is a non-drug and alcohol organisation – the local CVS [council for voluntary services],' he explains. 'That's been a fantastic place for our organisation to be based because we receive a lot of support and resources from the voluntary sector.' The arrangement is not without its downsides, however, and it was this that provided the initial impetus for the Recovery Foundation.

'Accolades are brilliant and we'll lap them up, but it's not what we set out to achieve... To be awarded the Queen's Award was a fantastic achievement for everybody involved. And attending a royal garden party – if someone had said that to me eight or nine years ago, I'd have laughed my head off...'

'It soon became apparent that what we were doing was growing but when I was looking to expand, the local funding channels that we had were diminishing,' he says. 'So I wanted to find ways for us to go about attracting additional funding so we could increase the range of work we do, and I set up a CIC as a way for us to be able to do things outside the scope of our current contract, which is restricted by the SLA [service-level agreement]. And also there were issues of people not wanting to fund a small organisation that was part of a larger organisation, when they looked at the larger organisation's overall income.'

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In June it was announced that SUIT had won one of the Queen's Awards for Voluntary Service, established to recognise the 'outstanding contributions made to local communities by groups of volunteers' and with an equivalent status for voluntary groups as an MBE. 'For me, accolades are brilliant and we'll lap them up, but it's not what we set out to achieve,' he says. 'But SUIT is made up completely of people in recovery from drugs, alcohol and criminal involvement, so to be awarded the Queen's Award was a fantastic achievement for everybody involved. And attending a royal garden party – if someone had said that to me eight or nine years ago, I'd have laughed my head off, to say the least.'

Drugs can be a particularly taboo issue in the Asian community, with people afraid to be seen accessing services and worries about bringing shame on their families. What sort of things can realistically be done to tackle that? 'I think there are a number of things – proactively encouraging people from different ethnic groups to access treatment and outreach work in the community, and also if we could get certain kinds of establishments and people onside I think that would help. I'm particularly thinking about faith groups, because a lot of people tend to turn to faith as a way of getting the help and support they need.'

While this would mean tackling prejudices in some instances, raising awareness is key, he believes, 'not just in the Asian community but any ethnic group, because public services are open to all members of the public, as the name suggests. So services need to be doing more to encourage all members of the community to access them.'

Should there be more drug workers from BME communities, in that case? Some people say that's a vital issue, while others are less convinced. 'I'm going to say yes because I think any workforce – particularly if they're public-facing and public-supporting – should be mirroring the communities they serve,' he states. 'That's not to say we should have positive discrimination, but in terms of connecting with individuals, I think if people from BME groups could see people in services who they could maybe relate to in terms of their ethnicity it would be a step in the right direction.'

One of his main passions remains peer mentoring, and it's an area of work he's hoping to expand. 'I've been heavily involved in it since before it was even called that,' he says. 'It's not a surprise to me that there's so much emphasis on it and it's so much in the limelight, because of the outcomes that can be achieved. One of the things I'm really looking forward to extending is helping other areas in developing really meaningful peer support-type programmes that add value to the local treatment systems.'

He's currently involved in doing that on a consultancy basis in another region, Telford and Wrekin, supporting an after-care service and 'really developing a robust way of evidencing what they do – having strong governance structures in place and effective monitoring tools so that they can really show and demonstrate to local stakeholders the difference they're making to their community.'

This is something he's now looking to do on a bigger scale, possibly through the creation of a social franchise of the model he's helped to develop in Wolverhampton. 'That means other areas can benefit from all the ups and downs and left and rights and diagonals we've been through, and have something really dynamic and innovative in place,' he says.

The consultancy work has also helped to give him some perspective on his own service and locality, he explains. 'It's only by coming out of your area that you can see all the things you have in place that you take for granted and other people don't have – performance management, financial systems, governance structures, a robust volunteer programme. These are all the things I'm working on in helping this organisation to develop.'

*****

On top of his work with SUIT and the Recovery Foundation, he's also sat on boards at the Skills Consortium for Substance Misuse and Public Health England, is soon to become part of the All Party Parliamentary Group on Drug Misuse and is a third sector representative on Wolverhampton's police and crime board. 'That's good on two counts,' he says. 'I can bring the background and knowledge of substance misuse, but also being from the BME community gives me a double-pronged approach to looking at supporting and influencing police objectives and plans. It's been really interesting to be involved.'

He's lately also become involved in Operation Black Vote and their West Midlands civic leadership programme. 'I thought it was a fantastic opportunity to get behind the scenes and have a look at some of the civic roles that affect all of us. So as part of that I've had training on becoming a trustee and I've been shadowing the leader of Wolverhampton City Council, Roger Lawrence, to kind of pick his brains and find out what his function and role is. When I shadowed him it was in the midst of some really challenging times in terms of funding cuts, so it was really interesting to see how he handled that.'

On top of all this he was also part of a campaign to get local MEP Neena Gill re-elected, and now has aspirations to possibly run himself at some point. 'I canvassed with Neena and just kind of badgered her and asked her questions, and she was really supportive,' he says. 'I was part of a successful MEP campaign so hopefully one day I'll get to run my own.' So does he ever have any free time? 'Well on top of that I've got two very young children,' he laughs, 'so I could do with a few more hours in the day and a few more days in the week.'

While it would be tough to pick a highlight out of the last few years, one would have to be meeting the Reverend Jesse Jackson, as part of the 50th anniversary commemoration of the march on Washington DC, he says. 'He said, "Learning and literacy are the key to liberation". He was talking about the civil rights movement but it's obviously the same for any vulnerable or marginalised groups, so I think it applies perfectly to substance misuse as well.' **DDN**

www.suiteam.com

REACHING OUT

The Reach Out festival in Bristol aimed to raise awareness of carers affected by loved ones' substance misuse. DHI's **Richard Brookes** reports.

For every person grappling with drug and alcohol misuse, it's estimated that at least five others are affected – husbands, wives and partners, mothers, fathers, siblings, children, grandchildren, friends, employers. Yet, as with most carers, their struggles go largely unacknowledged and under-supported.

The DHI Reach Out one-day event in Bristol – now in its seventh year – offered a unique opportunity for families and loved ones to share their experiences with peers and professionals. The event included social care professionals, families and carers already in service, and those hoping to learn more as they considered seeking support.

The programme included talks from family members and professionals, as well as a keynote speech from Duran Duran bassist John Taylor on his own personal experience of addiction as both user and concerned other. It also featured stories of recovery from three family members, who bravely chose to break the silence associated with caring for a loved one struggling with substance misuse and highlighted the value of accessing support. 'I was only interested in getting help for my son,' said one family member. 'The thought of getting help for me was not something I considered. It felt selfish.'

One of the key aims of the event was to gain first-hand insight from families and carers on how to improve services. With a wide range of professionals from across the south west present, Reach Out was an opportunity to give loved ones a voice where it mattered and play an active role in shaping services for others.

Rosie Phillips, DHI's CEO, said of the event, 'It is impossible to underestimate the effect of addiction on families and carers of those misusing. Many suffer anxiety, depression and poor health because of the stresses and strains in their lives. This conference brought them together, alongside drug treatment and other professionals, to enable them to shape services and get the best possible support.'

The *Helping your loved one by helping yourself* session worked to develop a user-generated toolkit on regaining control of your own life and wellbeing, designed by families and carers for families and carers. The toolkit is currently being edited and designed and will be freely available from DHI's website later this year.

Important suggestions for the toolkit included using case studies of family members' journeys through the service to give carers relatable insight into how their situation could be improved. It was also identified that clear, easy to understand information about the nature of addiction and the cycle of change that helps carers understand what is happening to their loved one was crucial, and that there needed to be greater promotion of the positive impact that looking after yourself can have on your loved one's chance of recovery.

The workshop was co-facilitated by Gareth Ellaway, treatment services manager for South Gloucestershire. 'This was an extremely positive experience for those involved, many of whom had previously accessed our families and carers services as clients. To now be able to turn what was for many a very harrowing experience into something positive that may help others was clearly very empowering,' he said.

It can take up to seven years for a family member or carer to seek help. A workshop on first steps for families and carers asked why it took so long to access support, and aimed to develop actions to address the situation. This session proved very popular with families and carers, who had plenty to say regarding their own experiences.

Workshop attendees identified a number of possible reasons for the delay in seeking help. Many families and carers had been purely focused on looking after their loved one and had no interest in seeking help for themselves. Some had felt they could 'handle the situation' within the family unit. It was only later they realised that their concept of support may have actually enabled their loved one to continue with their substance misuse.

The majority of participants also had no idea that support for families and carers was available, even after numerous meetings with their local GP or hospital, and there was a lack of general public awareness and understanding regarding the issue that left many feeling too isolated or ashamed to seek help.

Peter Main, Bristol's first openly gay lord mayor, also gave some insight as to how this issue specifically affects the LGBT community. Peter's partner died five years ago from complications caused by alcohol dependency. 'There is a double stigma for members of the LGBT community affected by a loved one's alcohol use,' said Main. 'They must not only summon up the courage to seek help regarding

The majority of participants also had no idea that support for families and carers was available, even after numerous meetings with their local GP or hospital.

their partner's addiction, but are then faced with the significant prejudice that still surrounds homosexuality.

'To raise awareness of support available you have to go out and engage with these communities directly. This is why after taking part in today's event I will be helping DHI promote their support services at the Bristol Pride festival in July.'

Many of DHI's family practitioners have raised the issue of it being difficult to persuade clients of the benefits of group support. Another workshop gave those who have been reluctant to attend groups the chance to experience a taster of how they work without committing to actively participating.

One carer commented, 'I had never felt comfortable enough about what was going on in my life to join one of the groups. I thought it would all be too raw. But I'm now more open to it, and can see it might be something I'll benefit from in the future.'

Keynote speaker John Taylor shared his own personal experiences of addiction and its impact on others. 'Events such as these are vital to both the families and support communities dealing daily with issues of addiction,' he said.

'So often they feel isolated, unclear of how to proceed and silenced by the stigma they perceive to be attached to this widespread and indiscriminate disease.'

A longtime supporter of DHI, Taylor spoke frankly about his own struggles and the value of support from services and peer support groups. 'A day like today is important because people need encouragement. One of the big problems is acknowledging the problem, that's the first thing. And then knowing there are solutions out there and connecting people is a big part of it too.'

DHI runs families services across Bath and North East Somerset, South Gloucestershire and Bristol, and the event was supported by South Gloucestershire Council, Bath and North East Somerset Council and Rotork. www.dhi-online.org.uk

The 2014 Adfam/DDN Families First conference will be held on 23 October in London, aimed at helping to equip family members and those who support them to deal with the challenges of addiction within the family. For more information visit www.drinkanddrugsnews.com

VOICES OF RECOVERY

BECOMING CHANGE-MAKERS

It's time to leave our little bubbles and make recovery visible, says **Alistair Sinclair**

WATCHING THE NEWS LAST WEEK, the brutality in Gaza, the tragedy in Ukraine, I reflected on the little bubble I live in. It's easier in the bubble. The brutality, horror and carelessness that exists outside seems so overpowering and huge. Despair poised, ready to envelop and suffocate. Some call this depression and give you pills and/or CBT. Some self-medicate, losing themselves in their dependencies. I cling on, just about, to the belief that in my bubble I can find new paths to tread.

But can I ignore what's happening outside? Surely what we say, what we do has to be rooted in an attempt to alter fundamental inequalities? Or else, just in terms of my own self-interest, where can I go, how will I recover? How will I be at ease when all the taking notice I do tells me that I live in an asylum that's making me and all the other inmates sicker?

In July's *DDN* I suggested that it's the sick and the afflicted that bring warnings, answers and healing in a world ravaged by the sane. Not a new concept but I thought it useful to throw out into a treatment and recovery world which often seems to view success as assimilation back into normal society, back into the consumerist/materialist bubble. I was trying to say that for me recovery, co-production and ABCD isn't about empowering communities to become new producers, consumers and responsible partners in a neo-liberal landscape.

It isn't about attacking the welfare state and the working-class people that make it work. It isn't about being praised by politicians and welcomed back into the fold. ABCD is a tool (be careful with tools) to enable individuals and communities to discover or re-discover their power, their agency and capacity to become change-makers. My kind of recovery is liberation, empowerment and social justice. I believe we should start talking about the kind of change we want to bring about, the sort of world we want to live in. I think it's time to pull recovery from the reductive treatment ghetto and perhaps start to leave our little bubbles behind.

Which is why the UKRF is promoting and supporting recovery month in September – a month which will make recovery more visible all over the UK and perhaps support a rejection of our default deficit thinking. It will be a month that will focus on community strengths and resilience. We want to celebrate and promote the passion, wisdom and strengths that exist in families, neighbourhoods and communities and nurture relationships within and across communities. We want to write new inclusive and hopeful stories.

Recovery month 2014 is shaping up. Writing this I'm aware of 37 events in the UK and the list is growing every day. Alongside the UK recovery walk in Manchester on 13 September there will be walks in Ireland, Scotland and Wales and local walks in other places. There will be festivals, film shows, workshops, cricket matches, parties, all sorts of stuff, big and small – lots of people coming together to share, learn and have fun. Lots of people stretching their bubbles, perhaps even stepping outside for a while. Making the path as they walk it.

Recovery month 2014 events: http://bit.ly/1xJqgN0
Recovery month 2014 t-shirts details here: http://bit.ly/1qPbVkz
Alistair Sinclair is UKRF director

FILLING THE GAP

The NNEF was encouraged by the success of its first free training day for needle exchange staff, says the forum's chair *Jamie Bridge*

'WE HAVE NO BUDGET FOR TRAINING.' We heard this plenty of times at previous NNEF events – when budgets get tight, one of the first casualties is staff training. Yet training is essential for this sector. We often have relatively high staff turnover, and staff need to be empowered with the knowledge and confidence to provide the best advice to our clients.

The National Needle Exchange Forum (NNEF) is a voluntary network that promotes and supports the provision of high quality needle and syringe programmes. In June, we organised our first ever free training event for needle exchange workers, with parallel courses offered on safer injecting, overdose prevention, peer distribution, and bacterial infections. Trainers from across the country were brought to Liverpool to deliver to more than 80 participants – and the event was kept free of charge thanks to the generous support of Frontier Medical Group, Liverpool John Moores University, and a number of exhibitors.

The feedback from the event was overwhelmingly positive: all of those who left feedback said that they would recommend future NNEF events to their colleagues, and that they were able to access training that they would otherwise not have been able to. As a result, the NNEF will look to provide more training events in the future – at locations across England – to support needle exchange staff as much as possible in their important, lifesaving work.

To find out more, join the forum at www.nnef.org.uk/nnef_join.html – membership is free.

LIFE-SAVING MESSAGES

Nigel Brunsdon was among the trainers at the NNEF event. He shares key messages from his workshop on preventing overdose

I WAS LUCKY ENOUGH to be asked to run two half-day workshops on promoting overdose prevention at the NNEF's free training event. Although drug services and needle programmes have always had a duty to reduce drug-related deaths, this often has in practice involved little more than asking someone if they have overdosed in the last four weeks, with very little in the way of follow-up. Some services do go further, but staff training around this is often just a small aspect of a wider training programme rather than intensive overdose prevention work.

> **'Training people in promoting overdose prevention messages has to include a large amount of "myth-busting".'**

Training people in promoting overdose prevention messages has to include a large amount of 'myth-busting'; both workers and people who use drugs can have fixed ideas learned from their peers and the media. Challenging these ideas requires sensitivity and understanding.

For example, explaining to a group that walking people around when they've overdosed won't help them. You're likely to come across someone who has done this in the past, and the person lived. They may have gone though years believing they saved someone's life, and you have to explain that not only did this not help, but that they might have put the person at a greater risk of injury from falls as well as increasing the overdose risk by delaying the process of getting help. Imagine how you might feel in that same situation.

Overdose prevention also has to be practical and realistic; take for instance the recovery position. Almost everyone I've trained has some idea of how to put people into the 'correct' position. But how often does this kind of training include coming across people who are not flat on their back with their hands by their sides. Unfortunately people don't always fall to the floor in a neat and tidy way, they might be slumped over, face down, or even wedged between furniture. If all we do is talk to people about artificially 'tidy' scenarios then they won't be confident responding in real life situations.

During the training at the NNEF, one exercise was for people to develop their own overdose education plans that could be incorporated into the kinds of programmes they worked in. This might be a formal one-hour one-to-one session, a group situation or even just small bite-sized chunks of information that can be delivered while supplying sterile injecting equipment. When developing this kind of plan, think about the resources you have – are you going to give people handouts? What practical exercises can you run (have you got access to a resuscitation doll?) and, of course, are there partner agencies you can work alongside to deliver this?

Both the sessions at the NNEF event were very well attended, showing that there is a real need for this kind of work from the point of view of the workers involved. The last drug-related deaths figures showed more than 500 people died from heroin use. With other drugs added the figures are more than 1,000 people, so this needs to be more of a priority than a couple of questions on an assessment.

Overdose prevention is something that should be done at every stage of drug service work, from brief interventions during needle sessions, right though to relapse prevention overdose work in rehab situations.

Nigel Brunsdon is community manager at HIT and a harm reduction trainer, www.injectingadvice.com

UK Recovery Walk 2014

The 6th UK Recovery Walk Greater Manchester

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GET INVOLVED, CELEBRATE & WEAR SOME PURPLE
Anyone can get involved. You can join the Walk, attend the many events around the country, speak to us, your local recovery organisation or just **wear something purple to show your affinity**!

To find out more about the UK Recovery Walk, to register for it, to see what's on during Recovery Month, or simply find out more about how to get involved, please visit:
www.ukrecoverywalk.org

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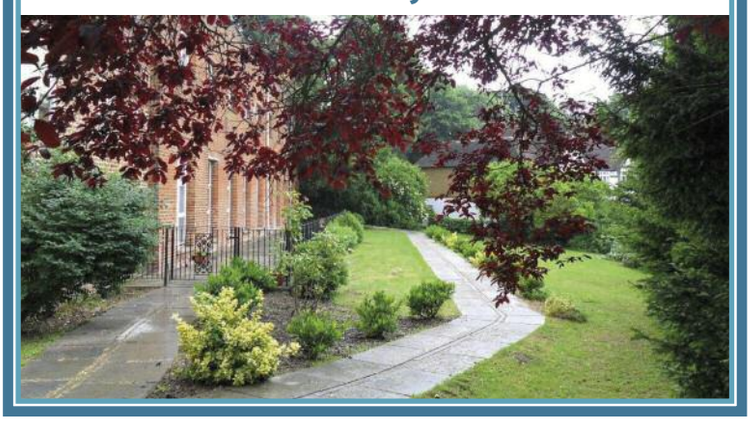

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